Testimony of

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on a

MEDICARE PRESCRIPTION DRUG BENEFIT

before the

SENATE FINANCE COMMITTEE

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Chairman Roth, Senator Moynihan, distinguished Committee members, thank you for inviting me to discuss the need, and our proposal, to provide prescription drug coverage for Medicare beneficiaries. This Committee will be a focal point of the debate around this important issue and it is a privilege to be before you today to provide the Administration's perspective.

We must act now to ensure that all beneficiaries have an affordable prescription drug benefit option. Pharmaceuticals are as essential to modern medicine today as hospital care was when Medicare was created. And the President believes that we have an extraordinary opportunity to address this shortcoming in the context of additional necessary reforms to the program that make it more effective, modern, and adequately financed.

Lack of prescription drug coverage among senior citizens and people with disabilities today is similar to the lack of hospital coverage among senior citizens when Medicare was created. Three out of five lack dependable coverage. Only half of beneficiaries have year-round coverage, and one third have no drug coverage at all. They must pay for essential medicines fully out of their own pockets, and are forced to pay full retail prices because they do not get the generous discounts offered to insurers and other large purchasers. The result is that many go without the medicines they need to keep them healthy, out of the hospital, and living longer lives.

Drug coverage is not just a problem for the poor. More than half of beneficiaries who lack coverage have incomes above 150 percent of the federal poverty level and millions more have insurance that is expensive, insufficient, or highly unreliable.

Even those with most types of coverage find it costs more and covers less. Copayments, deductibles and premiums are up. And coverage is often disappearing altogether as former employers drop retiree coverage and Medigap is not available to everyone. Clearly all beneficiaries need access to affordable prescription drug coverage option.

KEY PRINCIPLES

The President has identified key principles that a Medicare drug benefit must meet.

· **It must be a voluntary benefit accessible to all beneficiaries.** Medicare beneficiaries in both managed care and the traditional program should be assured of an affordable prescription drug option. Since access is a problem for beneficiaries of all incomes, ages, and areas, we must not limit a Medicare benefit to a targeted group. At the same time, those fortunate enough to have good retiree drug benefits should be able to keep them.

· **It must be affordable to beneficiaries and the program.** We must provide assistance that enables all beneficiaries participate. Otherwise, primarily those with high drug costs would enroll and the benefit would become unaffordable. And beneficiaries must have meaningful protection against excessive out-of-pocket costs.

· **It must be competitive and have efficient administration.** Beneficiaries must have bargaining power in the market place. And we must integrate the benefit into Medicare but use the private sector to deliver it in a competitive way.

· **It must ensure access to needed medications and encourage high-quality care.** Beneficiaries must have a defined benefit providing access to the medications that their physicians deem to be medically necessary, and they must have the assurance of minimum quality standards, including protections against medication errors.

· **It must be done in the context of broader reform.** The drug benefit should be a part of a larger plan to strengthen and modernize Medicare.

The President's plan meets these principles.

· Beneficiaries will have access to an optional drug benefit through either traditional Medicare or Medicare managed care plans. Those with retiree coverage can keep it and employers would be given new financial incentives to encourage the retention of these plans.

· Premiums will be affordable, with extra assistance for those with low-incomes.

· There will be no price controls or new bureaucracy; instead, the new benefit will be offered through private pharmacy benefit managers who can efficiently negotiate fair prices. All qualified pharmacies will be allowed to participate.

· Beneficiaries can get all drugs prescribed by their physicians from private benefit managers who meet minimum quality standards.

· The President's Budget includes the prescription drug benefit as part of a comprehensive plan to make Medicare more efficient and competitive and extend its solvency.

We have broad consensus that we must act now to establish a Medicare drug benefit. We have an historic opportunity provided by the growing budget surplus. We have an obligation to keep our commitment to meet the medical needs of seniors and the disabled. And this can only be done by making a voluntary, affordable, accessible, competitive, efficient, quality drug benefit available to all beneficiaries in the context of Medicare reform.

BACKGROUND

Prescription drugs can prevent, treat, and cure more diseases than ever before, both prolonging

and improving the quality of life. Proper use should minimize hospital and nursing home stays, and could in some cases substitute for more expensive care that is already covered by Medicare.

Recognizing that prescription drugs are essential to modern medicine, the private sector now includes outpatient drug coverage as a standard benefit in almost all policies. Further, all plans in the Federal Employees Health Benefits Program offer a prescription drug benefit. No one would design Medicare today without including coverage for prescription drugs. Prescription drugs are particularly important for seniors and disabled Americans, who often take several drugs to treat multiple conditions. All across the country, Medicare beneficiaries are suffering physical and financial harm because they lack coverage.

Current coverage for prescription drugs for Medicare beneficiaries is incomplete and unreliable. We project that this year more than half of Medicare beneficiaries will use prescription drugs costing $500 or more, and 38 percent will spend more than $1000. Each year, about 85 percent of Medicare beneficiaries fill at least one prescription. Yet one third of beneficiaries have no coverage for drugs at all and, in 1996, half did not have drug coverage for the entire year.

Forty percent of beneficiaries without coverage have incomes above 200 percent of poverty ($16,700 for a single person, $22,500 for a couple), demonstrating that this is not just a low-income problem. All these beneficiaries end up paying more for needed prescriptions because they do not get the discounts commonly offered to insurers and other large purchasers.

This situation is worse for the 10 million Medicare beneficiaries who live in rural areas. Nearly half of these beneficiaries have absolutely no drug coverage. They have less access to employer-based retiree health insurance because of the job structure in rural areas. And three-quarters of rural beneficiaries do not have access to Medicare+Choice plans and the drug coverage that many of these plans provide.

In 1996, about one-third of Medicare beneficiaries had private sector coverage offered by former employers to retirees. However, this coverage is eroding. The number of firms with 500 or more employees offering retiree health coverage dropped from 40 percent in 1994 to 30 percent in 1998, according to the employee benefits research firm Mercer/Foster Higgins (numbers for small firms would be even lower).

The true impact of this trend has not yet been realized, because some employers' decisions to drop coverage apply only to future retirees. Furthermore, a recent survey prepared for the Kaiser Family Foundation reported that 40 percent of large employers would consider cutting back on prescription drug coverage in the next three to five years. As today's workers retire, the population of Medicare beneficiaries with access to retiree coverage is likely to be well below the levels reported in our surveys.

About one in six Medicare beneficiaries today are enrolled in Medicare+Choice plans, most of which include some drug coverage. Although Medicare+Choice plans are only required to provide the traditional Medicare benefit package, the majority of them also provide prescription drugs, which is one reason why they have been popular with Medicare beneficiaries.

Nearly one-third of all beneficiaries, however, lack a Medicare+Choice option because they live in areas where there are no plans. And where plans are available, they have been raising premiums and copayments for drugs, while lowering caps on drug coverage. In 2000, three

quarters of plans cap benefit payments for brand-name drugs at or below $1000, and nearly one-third of plans cap this coverage at $500 or less, even though the majority of Medicare beneficiaries use prescription drugs costing $500 or more each year.

About one in eight Medicare beneficiaries have drug coverage through Medicaid. Eligibility for Medicaid, however, is restricted to beneficiaries under 100% of poverty, and the majority of beneficiaries eligible for such coverage -- 60 percent -- are not enrolled in the program. This enrollment problem persists despite increasing outreach efforts to enroll those who are eligible.

Roughly one in ten Medicare beneficiaries obtain drug coverage from a supplemental Medigap plan. Medigap coverage, however, is expensive, and its availability is not guaranteed except right after a beneficiary turns 65.

Costs for these policies are rising rapidly, by 35 percent between 1994 and 1998, according to Consumer Reports, in part because those being covered this way are less healthy than the average beneficiary. The General Accounting Office (GAO) found that almost half of all Medigap insurers implemented substantial increases in 1996 and 1997, with AARP -- one of the largest Medigap providers, and the only one offering a community-rated policy covering prescription drugs -- increasing rates by 8.5 percent in 1997, 10.9 percent in 1998, and 9.4 percent in 1999.

The GAO also found that Medigap premiums for plans that include drug coverage vary widely, both within and across States. For example, premiums charged to a 65-year-old beneficiary for the standardized "I" Medigap plan ranged from $991 to $5,943 in 1999. And the average premium for the standardized "H" Medigap plan ranges from $1,174 in Virginia to $2,577 in Georgia.

Furthermore, Medigap premiums increase with age in most States. In some parts of the country, beneficiaries over age 75 are paying more than $100 per month for a plan with drug coverage over and above the premium for a comparable plan without drug coverage. This occurs despite the fact that the maximum annual payment for drug costs in the "H" and "I" plans is only $1250 per year, barely over $100 a month.

THE PRESIDENT'S PLAN

The President has proposed a comprehensive Medicare reform plan that includes a voluntary, affordable, accessible, competitive, efficient, quality drug benefit that will be available to all beneficiaries. The President's plan dedicates over half of the on-budget surplus to Medicare and extends the life of the Medicare Trust Fund to at least 2025. It also improves preventive benefits, enhances competition and use of private sector purchasing tools, helps the uninsured near retirement age buy into Medicare, and strengthens program management and accountability.

The President's drug benefit proposal makes coverage available to all beneficiaries. The hallmark of the Medicare program since its inception has been its social insurance role. Everyone, regardless of income or health status, gets the same basic package of benefits. This is a significant factor in the unwavering support for the program from the American public and must be preserved. All workers pay taxes to support the Medicare program and therefore all beneficiaries should have access to a new drug benefit.

A universal benefit also helps ensure that enrollment is not dominated by those with high drug costs (adverse selection), which would make the benefit unaffordable and unsustainable. And, as I described earlier, lack of drug coverage is not a low-income problem - beneficiaries of all incomes face barriers.

The benefit is completely voluntary. If beneficiaries have what they think is better coverage, they can keep it. And the President's plan includes assistance for employers offering retiree coverage that is at least as good as the Medicare benefit to encourage them to offer and maintain that coverage. This will help to minimize disruptions in parts of the market that are working effectively, and it is a good deal for beneficiaries, employers, and the Medicare program.

We expect that most beneficiaries will choose this new drug option because of its attractiveness, affordability, and stability. For beneficiaries who choose to participate, Medicare will pay half of the monthly premium, with beneficiaries paying an estimated $26 per month in 2003. The independent HCFA Actuary has concluded that at least 50 percent of the premium must be subsidized in order to ensure adequate participation. A lesser subsidy would result in adverse selection and thus an unaffordable and unsustainable benefit.

Premiums will be collected like Medicare Part B premiums, as a deduction from Social Security checks for most beneficiaries who choose to participate. These beneficiary premiums would pay roughly half of program costs. Low-income beneficiaries would receive special assistance. States may elect to place those who now receive drug coverage through Medicaid in the Medicare drug program instead, with Medicaid paying premiums and cost sharing as for other Medicare benefits.

We would expand Medicaid eligibility so that all beneficiaries with incomes up to 135 percent of poverty would receive full assistance for their drug premiums and cost sharing. Beneficiaries with incomes between 135 and 150 percent of poverty would pay a partial, sliding-scale premium based on their income. The Federal government will fully fund States' Medicaid costs for the beneficiaries between 100 and 150 percent of poverty.

Under the President's plan, Medicare will pay half the cost of each prescription, with no deductible. The benefit will cover up to $2,000 of prescription drugs when coverage begins in 2003, and increase to $5,000 by 2009, with a 50 percent beneficiary coinsurance. After that, the dollar amount of the benefit cap will increase each year to keep up with inflation.

For beneficiaries with higher drug costs, they will continue to receive the discounted prices negotiated by the private benefit managers after they exceed the coverage cap. And, to help beneficiaries with the highest drug costs, we are setting aside a reserve of $35 billion over the next 10 years, with funding beginning in 2006. It will be available so that Congress and the Administration can work in collaboration to design protections for those with the greatest need.

Benefit managers, such as pharmacy benefit manager firms and other eligible companies, will administer the prescription drug benefit for beneficiaries in the traditional Medicare program. These entities will bid competitively for regional contracts to provide the service, and we will review and periodically re-compete those contracts to ensure that there is healthy competition. The drug benefit managers -- not the government -- will negotiate discounted rates with drug manufacturers, similar to standard practice in the private sector. We want to give beneficiaries a

fair price that the market can provide without taking any steps toward a statutory fee schedule or price controls. The drug benefit managers will have to meet access and quality standards, such as implementing aggressive drug utilization review and patient counseling programs. And their contracts with the government will include incentives to keep costs and utilization low while assuring a fairly negotiated contractual relationship with participating pharmacists.

Similar to the best private health plans in the nation, virtually all therapeutic classes of drugs will be covered. Each drug benefit manager will be allowed to establish a formulary, or list of covered drugs. They will have to cover off-formulary drugs when a physician certifies that a specific drug that is not on the formulary is medically necessary. Coverage for the handful of drugs that are now covered by Medicare will continue under current rules and will not be included in the new drug benefit package.

And Medicare+Choice plans will benefit from the President's plan. Beneficiaries enrolled in Medicare+Choice plans will receive this optional coverage through those plans, and the plans will use their existing management tools to negotiate prices and formularies. Today, most Medicare+Choice plans offer prescription drug coverage using the excess from payments intended to cover basic Medicare benefits. Under the President's proposal, Medicare+Choice plans in all markets will be paid explicitly for providing a drug benefit - in addition to the payment they receive for current Medicare benefits - so they no longer have to depend on what the rate is in a given area to determine whether they can offer a benefit or how generous it can be.

This will eliminate the extreme regional variation in Medicare+Choice drug coverage when only 23 percent of rural beneficiaries with access to Medicare+Choice have access to prescription drugs, compared to 86 percent of urban beneficiaries. And beneficiaries will not lose their drug coverage if a plan withdraws from their area or if they choose to leave a plan because they will also be able to get drug coverage in the traditional Medicare program. We estimate that plans will receive $54 billion over 10 years to pay for the costs of drug coverage.

Appeals Process

Under the President's plan, few appeals of coverage denials would be likely since pharmacy benefit managers would be required to cover all drugs that a physician prescribes. However, a process for appealing pharmacy benefit manager decisions by beneficiaries would be established similar to the highly effective system that exists for appeals of HMO care denials in the Medicare+Choice program. Benefit managers would be required to respond within set timeframes, state the reasons for a denial in writing, use denial notice forms that describe beneficiary appeal rights, maintain logs, and periodically report on requests for expedited appeals.

All appeals rejected by benefit managers would be automatically forwarded to an independent appeals contractor for review, and this independent contractor also would be required to act within set timeframes. Beneficiaries would be able to appeal an independent review contractor's decision to Social Security Administration Administrative Law Judges, and appeal those decisions to the Health and Human Services Departmental Appeals Board. Finally, beneficiaries would be able to appeal a Departmental Appeals Board decision in federal district court.

Administrative Workload

The administrative workload on the federal government for the drug benefit proposed by the President also would be relatively minimal, since the vast majority of decisions and day-to-day functions would be handled by the pharmacy benefit managers. The capacity of these benefit managers to process claims instantly has expanded rapidly in recent years, and we have no doubt that this capacity could be readily expanded by 2003 to administer our proposed drug benefit. There would be no need for the type of coverage determination process in the traditional Medicare program because the pharmacy benefit managers would establish their own formularies, and be required to cover off-formulary drugs whenever prescribed by a physician.

The federal role would primarily be in conducting competition for the pharmacy benefit manager contracts, overseeing the contracts, and ensuring a smooth interface with other Medicare programs and data systems. We now have a work group evaluating the most efficient way to meet the relatively limited staff and other resource needs that would be required.

MEETING BASIC PRINCIPLES

In any proposal to provide a prescription drug benefit for Medicare beneficiaries, it is essential that the key principles identified by the President be met.

· It must be a voluntary benefit accessible to all beneficiaries.

· It must be affordable to beneficiaries and the program.

· It must be competitive and efficient.

· It must ensure access to needed medications and encourage high-quality care.

Unfortunately, some of the proposals to establish a Medicare drug benefit fail to meet one or more of these criteria.

Proposals that provide assistance only to low-income beneficiaries fail to help millions of beneficiaries with no or undependable coverage. Most lacking drug coverage have incomes above 150 percent of poverty, and it is increasingly difficult for them to afford the medicines they need as drug prices rise faster than inflation. It also is essential that we maintain the principle that all Medicare benefits are equally available to all beneficiaries. This is a pillar of the program's strength and overwhelming support among the American people.

Proposals with a premium subsidy of only 25 percent would make the benefit unaffordable to many low and middle-income beneficiaries unable to shoulder the remaining 75 percent. As a result, the benefit would attract a disproportionate number of enrollees with high drug costs. That would drive up the price of premiums, which would further discourage those with lower incomes or lower drug costs from enrolling, and in the end result in an unsustainable program. As mentioned above, the independent HCFA actuary has concluded that a subsidy of at least 50 percent is essential to attract a range of enrollees wide enough to maintain an adequate risk pool.

Proposals with continuous or annual open enrollment periods would be especially vulnerable to

attracting enrollees with high drug costs because beneficiaries could wait until they had substantial drug costs before enrolling. This would exacerbate adverse selection problems caused by an inadequate premium subsidy. Proposals that link a drug benefit to a high-option Medicare plan with additional benefits like a stop-loss for out-of-pocket costs for Medicare's basic benefits also are less affordable. Beneficiaries who elect the high option would have to pay not only for drug coverage but also for all the other higher costs of the high option plan that many would not need, want, or be able to afford.

Proposals that fail to establish private sector benefit managers everywhere, and instead merely allow private plans to offer coverage when and where they wish, fail to ensure access for all beneficiaries. The benefit would be available only in regions where Medigap and other private plans step forward to offer it. Medigap insurers have already said they would not find stand-alone drug policies an attractive business proposition and are currently offering drugs less frequently. Medigap plans also have little experience negotiating with drug manufacturers and do not pool the purchasing power of seniors. That could well make the coverage unaffordable for many beneficiaries.

And, finally, proposals that do not include a minimum or specified benefit design cannot ensure access or high-quality care. They would allow insurers offering the coverage to "cherry-pick" by tailoring benefits in a way that would limit the value of the benefit to those with greater prescription drug needs. And they would not ensure that minimal safety protections, such as medication error prevention programs, are in place.

CONCLUSION

The need for a prescription drug benefit in Medicare is clear. The consensus across the political spectrum that it should be added is broad. The principles on which it must be based are strong. The opportunity is before us. The time to act is now. I look forward to working with all of you on this critical issue. I thank you for holding this hearing, and I am happy to answer your questions.

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